Patient Name

Date of Birth

Well Baby Check: 15 month visit questionnaire

Interval History:

Has your child had any major illnesses, ER or Urgent Care trips since your last appointment in the office? No ☐ Yes ☐

Has your child had any reactions to vaccinations in the past? No ☐ Yes ☐

Development:

Can your child scribble with a crayon/pencil? Yes ☐ No ☐

Can your child drink from a cup? Yes ☐ No ☐

Does your child feed him/herself finger foods? Yes ☐ No ☐

Does your child say at least 3 words (e.g. "Hi", "No", "Uh-oh")? Yes ☐ No ☐

Does your child say "words" that you don't understand (jargoning)? Yes ☐ No ☐

Does your child understand and follow simple commands? Yes ☐ No ☐

Can your child walk alone? Yes ☐ No ☐

Can he or she bend (stoop) to pick something up and stand up again? Yes ☐ No ☐

Can your child crawl up stairs? Yes ☐ No ☐ N/A ☐

Can your child stack two blocks or objects (one on the other)? Yes ☐ No ☐

Do you read to your child regularly? Yes ☐ No ☐

Do you have concerns about how your child hears or speaks? No ☐ Yes ☐

Do you have any concerns about how your child sees? No ☐ Yes ☐

Does your child hold objects close when trying to focus? No ☐ Yes ☐

Do your child's eyes appear unusual or seem to cross, drift or be lazy? No ☐ Yes ☐

Do your child's eyelids droop or does one eyelid tend to close? No ☐ Yes ☐

Dental Health:

Do you help your child brush and floss his/her teeth daily? Yes ☐ No ☐

Does your child's primary water source contain fluoride? Yes ☐ No ☐ Unsure ☐

If no, does your child take a fluoride supplement? Yes ☐ No ☐ N/A ☐

Do you know a dentist to whom you can bring your child? Yes ☐ No ☐

Staying Healthy/Safety/Tobacco Exposure:

Does your child watch TV, play video games, or use a smart phone or tablet? No ☐ Yes ☐

Does your home have a working smoke detector? Yes ☐ No ☐

Have you turned your water temperature down to low-warm (less than 120 degrees)? Yes ☐ No ☐ N/A ☐

If your home has more than one floor, do you have safety guards on the windows and gates for the stairs? Yes ☐ No ☐ N/A ☐

Does your home have cleaning supplies/medicines/matches locked away? Yes ☐ No ☐

Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone? Yes ☐ No ☐

Do you always stay with your child when she/he is in the bathtub? Yes ☐ No ☐

Do you and your child spend time near water (pool, river or lake)? No ☐ Yes ☐

If so, is your child always safely supervised? Yes ☐ No ☐ N/A ☐

Do you use sunscreen when your child is outdoors? Yes ☐ No ☐

Do you always place your child in a rear-facing car seat in the back seat? Yes ☐ No ☐

Is your car seat the right one for the age and size of your child? Yes ☐ No ☐

Do you always check for children before backing your car out? Yes ☐ No ☐

Does your child spend time in a home where a gun is kept? No ☐ Yes ☐ Skip ☐

If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun? Yes ☐ No ☐ N/A ☐

Does your baby spend time with anyone who smokes? No ☐ Yes ☐

Risk Assessment for Lead Exposure:

Does your child participate in any publicly supported programs (Medi-Cal, CHDP, Healthy Families, WIC)? No ☐ Yes ☐

Does your child live in or regularly visit a house or child care facility built before 1950? No ☐ Yes ☐

Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been renovated or remodeled (within the last 6 months)? No ☐ Yes ☐

Does your child have a sibling or playmate who has or did have lead poisoning? No ☐ Yes ☐

Does your child take any imported remedies or supplements? No ☐ Yes ☐

Tuberculosis Screening:

Was your child born in a country with an elevated TB rate? No☐ Yes ☐
This includes all countries ***other than*** the United States, Canada, Australia, New Zealand, or countries in western or northern Europe.

Has your child visited or lived in a country with an elevated TB rate ***for one month or more***? (Countries other than those listed above) No☐ Yes ☐

Has your child had contact with someone (including family member, childcare provider, or other caretaker) with known TB infection, or who has been treated for TB infection? No☐ Yes ☐ Unsure ☐

Is your child immunosuppressed (currently or planned)? No☐ Yes ☐
This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications.

Sleep:

How many hours does your child sleep at night? ____ hours

How many hours does your child nap throughout the day? ____ hours

Does your child sleep through the night without feeding? Yes☐ No ☐

Nutrition/ Physical Activity:

How much milk does your child drink? _____ oz per day. Type: [breast milk] ☐ [formula] ☐ [whole milk] ☐ [other _____] ☐

How much juice does your child drink in 24 hours? ____ oz

Is your child eating fruits and vegetables at least two times per day? Yes☐ No ☐

Does your baby drink or eat 3 servings of calcium-rich foods daily, such as milk, soy milk, cheese, yogurt, or tofu? Yes☐ No ☐

Does your child eat junk foods such as chips, fries, ice cream or fast food more than twice per week? No☐ Yes☐

Does your child drink soda, sports drinks, energy drinks or other sweetened drinks? No☐ Yes☐

Does your child eat meat (such as chicken, fish, beef or pork)? Yes☐ No ☐

Does your child play actively most days of the week? Yes☐ No ☐

Do you have any concerns about your child's weight or feeding? No ☐ Yes ☐

Elimination:

Does your child have bowel movements on a regular basis with a normal (soft) consistency? Yes☐ No ☐

Please list any medications or supplements your child is taking: _____

Who lives in the home with your child? _____

Who provides daytime care for your child? _____

Please list any new major family medical issues: _____

Please list any known allergies to medicines: _____

Please list any known food allergies: _____

Do you have any concerns about your child's development, or any other concern you would like to discuss with your provider?

_____

_____

Parent or Guardian Signature: _____

Date: _____

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	☐ **Patient Declined the SHA**
PCP's Signature		Print Name:			Date:

Ver.12-12-17/Edited 10-10-18

M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes ☐	No ☐
2. Have you ever wondered if your child might be deaf?	Yes ☐	No ☐
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes ☐	No ☐
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs)	Yes ☐	No ☐
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	Yes ☐	No ☐
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	Yes ☐	No ☐
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	Yes ☐	No ☐
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	Yes ☐	No ☐
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	Yes ☐	No ☐
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes ☐	No ☐
11. When you smile at your child, does he or she smile back at you?	Yes ☐	No ☐
12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes ☐	No ☐
13. Does your child walk?	Yes ☐	No ☐
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes ☐	No ☐
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do)	Yes ☐	No ☐
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes ☐	No ☐
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	Yes ☐	No ☐
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes ☐	No ☐
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes ☐	No ☐
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee	Yes ☐	No ☐

Child's Name: _____ DOB: _____

Completed by: _____ Date completed: _____